NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Statement on

"Medicaid Prescription Drugs: Examining Options for Payment Reform"

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Subcommittee on Health
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Medicaid Prescription Drugs: Examining Options for Payment Reform

Mr. Chairman and Members of the Subcommittee, My name is Craig Fuller, I am President and CEO of the National Association of Chain Drug Stores (NACDS), and I am very pleased to provide to you with our organization's views regarding Medicaid payment reform options for prescription drugs. NACDS represents more than 200 chain pharmacy companies that operate more than 35,000 community-based retail pharmacies, where the majority of all Medicaid prescriptions are dispensed. Issues and policies that affect Medicaid reimbursement for prescription drugs are of critical importance to our association and our membership.

I. Criteria for Medicaid Prescription Drug Payment Reform

We encourage the Subcommittee to keep the following three points in mind as Medicaid prescription drug payment reform options are considered:

- **Use Current, Market-Oriented, Retail-Based Prices:** Any reforms made to the current AWP-based payment system for Medicaid prescription drugs must result in reimbursement that reflects current, market-based prices at which pharmacies purchase both brand and generic drugs. Reimbursement methods that use retrospectively-determined prices, or are not reflective of the prices paid by the retail class of trade, will underpay pharmacies for Medicaid prescriptions and may create access problems for Medicaid recipients. Moreover, pharmacies must be paid adequately to dispense these prescriptions to Medicaid recipients.

- **Encourage Generic Drug Dispensing:** Payment policies should encourage pharmacy providers to dispense lower-cost generic drugs when possible and appropriate. Every time a pharmacist dispenses a generically equivalent drug instead of the off patent brand name counterpart, the Medicaid program saves an average of about $45. Every time a pharmacist receives permission from the physician to dispense a generic drug that is therapeutically equivalent to a brand name single source drug, the Medicaid program saves an average of about $100.

- **Require Proportional Cost Containment Contribution:** For the purposes of this year's budget reconciliation bill, each sector contributing costs to the Medicaid prescription drug program must make a proportional contribution to cost control. This includes pharmaceutical manufacturers, pharmacists and Medicaid recipients.

  States have already taken hundreds of millions of dollars out of Medicaid pharmacy reimbursement over the past several years. Yet Medicaid prescription drug spending continues to escalate because reducing pharmacy reimbursement does little to slow the growth of drug spending. That is because drug spending is being driven by increasing drug product costs and increasing drug use, not dispensing fee or pharmacy payments. Medicaid pays pharmacies for both the drug product dispensed, as well as the cost of dispensing. Pharmacies have no control over 80 percent of the costs of brand name drug prescriptions, which is the cost of the drug products we buy from manufacturers.

Reimbursement reductions reduce pharmacy payments only, not the costs of goods. It is unfair to place 100 percent of the cost containment burden on only 20 percent of the cost of the program; that is, retail pharmacy gross margins.

II. Current Status of Medicaid Prescription Drug Payment Policies

Total Medicaid pharmacy payments are based on two components: drug product reimbursement and dispensing fee. Consistent with the flexibility given to states, some states have higher reimbursement rates for pharmaceutical products and lower dispensing fees, while others have lower reimbursement rates for products and higher dispensing fees. The bottom line is that the total payment made has to be adequate to pay pharmacies to cover their costs of buying the drug, dispensing the drug, and earning a reasonable return on a Medicaid prescription.

Moreover, when policymakers consider whether a particular level of Medicaid reimbursement is "adequate" they often overlook other important factors that have an impact on revenues that a provider *actually* derives from Medicaid. For example, many states charge co-payments for Medicaid prescriptions, ranging from 50 cents to $3 per prescription. NACDS supports the use of reasonable Medicaid prescription co-payments as a way of making individuals take more responsibility for their health care. However, we also know that there are many recipients that truly cannot pay, even these small amounts. Pharmacies must provide Medicaid recipients with their prescriptions, even if a recipient cannot or will not pay the co-payment. Moreover, federal law prohibits Medicaid from reimbursing pharmacies for unpaid co-payments, so unpaid co-payments reduce pharmacies' revenues.

Because many states have been imposing steeper co-payments on recipients over the past few years, the rate of non-collection by pharmacies has been increasing, affecting the overall revenues that pharmacies derive from Medicaid prescriptions. Pharmacies should not shoulder the burden of these uncollected co-payments.

The net profit margin of community retail pharmacies is only about 2 percent. Pharmacies are low-margin health care providers, and even small changes in pharmacies' revenue streams can mean the difference between whether the pharmacy's doors remain open or have to close. Thus, it is vitally important that pharmacy payment rates be adequate to maintain Medicaid recipients' access to pharmacy services.

A. Pharmacies Working With States to Achieve Medicaid Pharmacy Cost Savings

Pharmacy providers are working successfully with many state Medicaid programs to help implement cost savings and quality improvement options that have helped save tens of millions of dollars for states and the Federal government. These include programs to increase use of lower-cost generic medications, disease management programs, step therapy programs, prior authorization and preferred drug list programs, and others.

We view ourselves as partners with the states in achieving savings, although these programs come with significant administrative costs to pharmacies and pharmacists, and little compensation.

Federal policymakers should encourage the appropriate use of lower-cost generic drugs. There is significant room for growth for generics in Medicaid. Generic drugs account for over half of all prescriptions dispensed in Medicaid, but only about 17 percent of all Medicaid prescription expenditures. This discrepancy is due to the significant difference in average reimbursement paid by Medicaid for patented brand name medications relative to generics. In 2004, the average reimbursement for a patented brand name drug was $122, while the average reimbursement for a generic was only about $20, less than one-sixth the amount for patented brands. Even the generally larger rebates on brand drugs cannot make up such a large difference.

Twenty-three (23) of the top 25 generic products dispensed by Medicaid programs in 2004 had an average reimbursement of $20 or less per prescription. Sixteen (16) of these medications were reimbursed at an average of less than $15 per prescription and 12 were reimbursed at under $10 per prescription. For these reasons, we encourage policymakers to recognize the importance of maintaining incentives within Medicaid to dispense generic-equivalents drugs.

Despite the tremendous cost savings possible from the use of generic drugs, generic dispensing rates in states vary widely. Data from the first quarter of 2005 found that the average state Medicaid generic dispensing rate was about 51 percent. However, the top 5 states were Washington (60.5%), Oregon (59.5%), Alabama (59%), New Mexico (58.9%), and Hawaii (58.3%). On the opposite end of the spectrum, however, the Medicaid generic dispensing rates were lowest in Connecticut (47.1%), California (46.9%), Texas (46.4%), Louisiana (44.5%) and New Jersey (42.4%). These stark differences in generic dispensing rates – 18 percent between the highest and lowest states – can be explained by a number of factors. However, if all states were able to increase their generic dispensing rates to 60.5% like Washington, the Medicaid program would save an estimated $3.5 billion this year. A complete analysis of state Medicaid generic dispensing rates is appended to this statement.

Researchers consistently find that increased use of generic drugs for off-patent brand name drugs could provide considerable savings to consumers and plan sponsors, including states and the federal government. In fact, as the budget reconciliation process moves forward, policymakers should consider whether increased use of generic drugs in Medicaid will generate most of the savings that might be needed for the budget target. For example:

- A study published in this month's *Annals of Internal Medicine* examines generic substitution for a large, nationally representative sample of adults. This study found that although over half of this group's outpatient prescriptions from 1997-2000 were for multiple source drugs, only 61 percent were dispensed as generics. If generic equivalent drugs had been dispensed in every instance where an off-patent brand name drug was dispensed, national savings could have been around $8.8 billion per year.[1]

[1] Haas, et al., Potential Savings from Substituting Generic Drugs for Brand Name Drugs: MEPS, 1997-2000; Annals of Internal Medicine, June 2005

For dual eligibles at least age 65, the savings from substitution of generic-equivalent drugs was $1.7 billion per year, while for the under-65 Medicaid population, the savings was $388 million per year.

- A study published in 2003 by the journal *Health Services Research* estimated that Medicaid could have saved up to $229 million in 2000 if generic equivalent drugs had been broadly substituted for off-patent brand name drugs.[2]

These studies all focus on substitution of generic equivalent products for off-patent brand name products. Even greater savings could be achieved if patients were able to use a generic drug or lower cost brand name drug that provided similar therapeutic benefit in place of a higher-cost patented, sole source brand name drug.

B. Medicaid Benefits from Generic Price Competition Generated by Retail Pharmacy

Medicaid benefits from the intense generic drug price competition and price transparency generated by retail pharmacies. The purchasing leverage of retail pharmacy forces competition among generic drug makers to earn a pharmacy's business. This lowers generic prices to pharmacies, and these lower generic prices are passed along to consumers.

Medicaid also benefits from generic drug price competition between retail pharmacies because Medicaid programs typically reimburse pharmacies the "lower of" the program's payment formula for a generic drug (i.e., FUL plus dispensing fee or MAC plus dispensing fee) *or* the pharmacy's "usual and customary" charge to the cash paying public. In many cases the Medicaid program pays a pharmacy's lower "usual and customary" price rather than the amount determined by the generic payment formula. As a result of competitive forces in the generic marketplace, the average generic prescription reimbursement in Medicaid has only increased by about $7 per prescription over the last 7 years, from $13 in 1998 to $20 today, while the average brand name prescription reimbursement has almost doubled from $63 in 1998 to $122 today. Clearly, Medicaid is benefiting from the price competition for generic drugs generated by retail pharmacy at multiple levels in the distribution chain.

Almost 60 percent of all Medicaid generic prescriptions have Federal Upper Limits (FULs), meaning that the pharmacy is reimbursed the same amount for a generic medication regardless of the price of the product purchased by that pharmacy. The FUL is set at 150 percent of the lowest price published in the national pharmaceutical pricing compendia for a generic version of a drug product. A FUL is established once there are three nationally-available sources of supply for the generic. The current FUL system, while not perfect, works well in balancing the needs of pharmacies to have sufficient economic incentives to dispense generics to Medicaid recipients, coupled with Medicaid's desire to not overpay for generics.

The FUL gives pharmacies the incentives to drive down the prices of generics below the FUL so the pharmacies do not lose money. Medicaid benefits from this price competition.

[2] Fisher, et al., Economic Consequences of Under Use of Generic Drugs: Evidence from Medicaid and Implications for Prescription Drug Benefit Plans, Health Services Research, 2003; 38: 1051-63.

At the same time, the fact that the pharmacy can retain any small margin between the FUL and its acquisition cost gives it an incentive to drive a hard bargain with the generic companies, as well as compensates for a dispensing fee component that may be inadequate. In our view, the current incentives are aligned appropriately for both pharmacies and Medicaid to dispense generics.

However, if pharmacy reimbursement were to be based on some markup of actual "acquisition costs," the incentives would change for pharmacy providers in terms of generic dispensing. For example, if Medicaid adopted Medicare Part B's policy to pay for covered drugs at ASP (Average Sales Price) plus 6 percent, a pharmacy will derive more revenue from dispensing a brand name drug with an ASP of $100 ($106) than it would derive from dispensing a generic with an ASP of $20.00 ($21.20). Thus, the economic incentives built into the ASP system would actually raise Medicaid costs by encouraging the dispensing of more expensive brand name drugs.

C. Competition Works for Drugs without Payment Limits

Even in cases where a FUL or MAC (Maximum Allowable Cost) is not established for a generic drug, or is not established as soon as multiple sources of supply become available, competitive forces at the retail level help to lower overall Medicaid costs for generics. A good case in point is what occurred when Prozac (known generically as fluoxetine) became available in generic form in August 2001. Medicaid was paying $2.86 per capsule total reimbursement for brand name Prozac in August 2001, and the price of the first generic (which had an FDA-granted six-month exclusivity period) was $2.46.

During the six-month period of exclusivity, when only one generic version can be sold as a result of government policy, pharmacies are essentially "price takers" – we have little leverage over a single source of supply of a generic drug. However, when there are multiple sources of supply for a generic drug, pharmacies become "price makers." We can create competition between the multiple sellers of these generic products.

After the exclusivity period for the first fluoxetine generic expired in early 2002 and multiple generics came to the market, Medicaid reimbursement for generic fluoxetine decreased rapidly. According to data we have analyzed, the average generic reimbursement for fluoxetine is now about $0.66 per capsule, or almost 75 percent less than the reimbursement paid when the product first became available generically. The rapid reduction in the reimbursement Medicaid pays for this generic resulted from market forces and generic competition that drove down the overall price of generic fluoxetine. Medicaid benefits each and every day from this continued competition. Medicaid's paying $0.66 per capsule total reimbursement for fluoxetine is much less than the current reimbursement rate of $3.37 per capsule for brand name Prozac.

D. Policymakers Should Consider Reimbursement for Total "Market Basket"

We think it is both fair and good public policy to consider the adequacy of reimbursement paid to pharmacies by looking at their entire Medicaid "market basket" of drugs provided by pharmacies, by not singling out the reimbursement paid for certain medications.

With 56,000 community retail pharmacies and upwards of 60,000 individual drug products available in the marketplace, the pharmacy reimbursement system is built on a series of averages and estimates. These include the average discount paid by the average pharmacy on the average wholesale price for prescription products and the average cost of dispensing a prescription at the average pharmacy. Such a system will have inherent highs and lows in the various components. But in the end, Medicaid and pharmacy providers need to strike a fair balance that would assure - in the aggregate - that Medicaid does not overpay or underpay, and that providers are adequately compensated for the "market basket" of drugs they provide.

In this regard, we sometimes hear criticism that pharmacies are making excessive markups on Medicaid generic drugs. Pharmacies do not "mark up" the prices on prescriptions dispensed to Medicaid recipients. Payment amounts are based on formulas developed by the state using Federal guidelines. Here are some of our perspectives on this issue:

- **Considering Margins Based on Percentages is Misleading**: First, the perceptions about these so-called "excessive markups" are fueled by the use of "percentages" to express the "markup" that the pharmacy retains on generic drugs, rather than considering the absolute dollar margin involved. Using percentages unfairly make the payments made by Medicaid look excessive. For example, if a state paid a pharmacy $5 for a generic that cost the pharmacy $1 to purchase, the markup would be only $4, yet the percentage markup would be 500%. In contrast, if the state paid the pharmacy $110 for a brand name drug that cost the pharmacy $100, the markup would only be 10%, but the absolute difference would be $10, greater than the 400% markup on the lower-cost product.

- **Generic Dispensing Incentives are Necessary and Appropriate:** Because the drug product cost for a generic prescription is lower than a brand, policy makers should be sure that the gross margin made by the pharmacy on a generic prescription is equal to or greater than that made on a brand. Otherwise, the pharmacy may be economically indifferent as to whether a brand or generic is dispensed because the pharmacy would make the same gross margin revenue regardless of the product dispensed. It matters to Medicaid because the state saves close to $45 each time a generic equivalent is dispensed for an off-patent brand.

- **Many Generics are Dispensed at a Loss:** In 2004, twelve of the top 25 generic prescription medications paid for by Medicaid were reimbursed at an average of less than $8 per prescription. With a pharmacy's average cost to dispense a prescription estimated to be around $9.45 per prescription, pharmacies are losing money each time they dispense one of these medications to a Medicaid recipient. These prescription reimbursement losses are offset by other prescriptions where the reimbursement may be higher than the pharmacy's overall costs to dispense.

If this current system based on "averages" were to change, fundamental changes in other parts of the system would also be necessary—such as substantial increases in pharmacy dispensing fees—to assure that pharmacies are adequately reimbursed and that they are still able to provide pharmacy services to Medicaid recipients.

We are also appending to this statement a letter than NACDS sent to the Congressional Budget Office (CBO) last year that raised issues and concerns with a paper that examined Medicaid reimbursement policies.[3] We believe that the paper overlooked many important factors about the current Medicaid pharmacy reimbursement system, and was overly critical of the payments made to pharmacies for generic drugs. We urge that policymakers read the NACDS response to the paper.

III. Medicaid Prescription Drug Payment Reform Options

With that background regarding the current Medicaid pharmacy reimbursement system, it is now important to consider the implications of various other alternatives to AWP (Average Wholesale Price) to reimburse pharmacies under Medicaid. These alternatives include ASP (Average Sales Price), AMP (Average Manufacturers Price), and WAC (Wholesale Acquisition Cost).

A. Use of Average Sales Price (ASP) as Medicaid Prescription Drug Payment Option

To achieve some of its Federal budget savings targets for the next 5 years, the Administration has proposed using ASP, rather than AWP to reimburse pharmacies for Medicaid prescriptions. In fact, unlike most states that reimburse pharmacies for both the cost of the prescription drug and a reasonable dispensing fee, the administration proposes to reimburse pharmacies ASP plus 6 percent for drug and dispensing costs. This proposal would generate $5.2 billion in Federal savings over the next 5 years, or a combined savings of $9.2 Federal and state savings. This amount represents almost 23 percent of pharmacy's Medicaid gross margins over this time period, a significant reduction by any measure.

Policymakers should understand that all of the savings under this policy would be achieved at the expense of pharmacists. None of the savings would come from reducing the pharmacy's costs of prescription drugs, which account for 80 percent of the program's total costs, because pharmacies have no upstream leverage with brand name manufacturers. We cannot force brand name drug manufacturers to lower their charges to us for the cost of goods.

Reducing pharmacy Medicaid gross margin prescription revenues by 23 percent could result in significant access problems for Medicaid recipients, as pharmacies may have to reduce hours or close stores in response to this significant loss of gross margin revenues. ASP has other problems as well, which are described below.

- **ASP Does Not Represent Prices at Which Retail Pharmacies Purchase Drugs**: ASP is calculated as a "weighted average sales price" across all payors (except direct Federal sales) for a particular pharmaceutical, net of various discounts and rebates given by the manufacturer to the purchaser. However, retail pharmacies are generally charged higher prices than other pharmaceutical purchasers, and don't have access to the same discounts, rebates, and price concessions of other purchasers. This would mean that pharmacies would buy drugs at a higher price than they would be reimbursed under ASP.

[3] Medicaid Reimbursements to Pharmacies for Prescription Drugs: CBO, December 2004.

- **ASP does not Account for Other Costs to Pharmacies:** There are other costs involved in getting the drug to the pharmacy that ASP does not account for, such as the pharmacy's costs to manage an inventory, the costs of getting the drug to the local pharmacy site, and the costs of complying with state and Federal pharmaceutical regulations. Even adding a markup factor to the ASP amount (e.g. ASP +6 percent) may not make a pharmacy whole just for acquiring the drug, no less the costs of storing, inventory, warehousing, and distribution of the drug. This could force participating pharmacies to provide these products at a loss, and create potential access problems for Medicaid recipients.

- **ASP is Not Based on Current Market Prices:** ASP is an outdated price, since it is calculated on data that is two calendar quarters old. Thus, it would not reflect the current prices at which retail pharmacies are purchasing prescription drugs. If ASP had been in effect on January 1, 2005 for Medicaid, community retail pharmacies would have been significantly disadvantaged in terms of Medicaid reimbursement for brand name drugs. That is because many brand name manufacturers increased prices in excess of 6 percent at the beginning of the year. Because the first quarter 2005 ASP rates would have been based on third quarter 2004 (July-September) sales data reported by the manufacturers, retail pharmacies would have to absorb any price increases after September 2004, the end of the third quarter 2004, all the way through March 2005.

- **ASP Proposal Does Not Envision Higher Medicaid Pharmacy Dispensing Fees:** The President's budget proposal does not include additional funds for pharmacy dispensing fees that would compensate for reductions in payment for drug products resulting from the new ASP methodology. Medicare Part B moved in January to an ASP plus 6 percent reimbursement for the few oral drugs covered by Medicare Part B, but CMS is paying a supplying fee of $24 per prescription. This was because CMS recognized that the move to an ASP-based system requires a significant increase in the pharmacy's dispensing fee, or Medicare beneficiaries would have a hard time finding a retail pharmacy that would fill their Part B prescriptions.

- **ASP Does Not Encourage Generic Dispensing:** Retail pharmacies are not given incentives to dispense lower-cost generics under an ASP-based system. Because generics have a lower cost basis that brand name drugs, an ASP-based system gives pharmacies incentives to dispense brands because they would make more money under an ASP plus 6% system for brands than generics (i.e. 6% of a $100 brand is $6, but 6% of a $20.00 generic is only $1.20).

We are encouraged that some members of Congress and other policymakers are recognizing that the use of ASP as an alternative reimbursement metric to the current formula may create more issues than it solves.

B. Use of Average Manufacturers Price (AMP) as Medicaid Prescription Drug Payment Option

The use of "Average Manufacturers Price" (AMP) as a potential Medicaid payment or reimbursement option has similar problems to the use of ASP. AMP is defined as the average price paid to manufacturers by wholesalers for drugs distributed to the retail class of trade. AMP was created in OBRA 90 for the purpose of calculating the Medicaid drug rebates paid by manufacturers to states. However, there are several problems that exist with the use of AMP as a reimbursement metric.

- **AMP Reflects Manufacturer's Sales, Not Pharmacy's Purchasing Costs:** Like ASP, AMP is a measure of a manufacturer's revenue for a particular drug in a particular calendar quarter, and does not represent the prices at which retail pharmacies purchase drugs from wholesalers, or reflect the costs that pharmacies incur in purchasing and maintaining a pharmaceutical inventory. Thus, to approximate a pharmacy's acquisition costs for Medicaid drugs, AMP would have to be increased by a significant percentage.

- **AMP Does Not Account for Manufacturers' Price Increases:** If AMP had been in effect on January 1, 2005 for Medicaid, community retail pharmacies would have been significantly disadvantaged regarding Medicaid reimbursement for brand name drugs because many brand name manufacturers increased prices in excess of 6 percent at the beginning of the year. Because the first quarter 2005 AMP rates would have been based on third quarter 2004 (July-September) sales data reported by the manufacturers, retail pharmacies would have to absorb any price increases after September 2004, the end of the third quarter 2004, all the way through March 2005.

- **AMP includes Mail Order Sales**: Unlike ASP, AMP is calculated for the retail class of trade only; however, like ASP, AMP is a retrospectively determined price and can be up to six months outdated. AMP includes both sales to retail pharmacies and mail order pharmacies, and retail pharmacies do not have access to the same discounts and rebates that mail order pharmacies do. As a result, using AMP may mean that retail pharmacies will be underpaid for Medicaid prescriptions because the reimbursement will be calculated off a "blended" base, including mail order sales. This would mean that the AMP basis used to reimburse pharmacies would be lower than if just true retail community pharmacy sales had been used to calculate AMP.

- **Significant Variation Exists in AMP Calculations:** Many government reports, including a recent report from the GAO, indicate that there is wide variation among the manufacturing community in calculating AMP. Final rules have never been published by CMS regarding the exact methodology that manufacturers should use in calculating the AMP values for their drug products. Therefore, in some cases, manufacturers may be calculating an AMP value that would underpay pharmacies for Medicaid prescriptions. Guidelines should be published that help manufacturers better understand how to calculate AMP so the rebate payments they make to states are accurate.

- **AMP Discourages Generic Dispensing:** Like ASP, using AMP would discourage the use of generics. Because generics have a lower cost basis than brand name drugs, an AMP-based system gives pharmacies incentives to dispense brands because they would make more money under an AMP plus 6 percent system for brands than generics (i.e. 6 % of a $100 brand is $6, while 6% of a $20.00 generic is $1.20). An AMP system does not encourage pharmacies to dispense generic drugs. Moreover, in some calendar quarters, the AMP for a particular generic might be a negative number. That can happen if the manufacturer's discounts and rebates for a given year were paid out disproportionately in a particular calendar quarter. It would be difficult to base a reimbursement amount to pharmacies on a negative number.

C. Retail Pharmacy Encourages WAC-Based Reimbursement for Brand Drugs

NACDS has developed an alternative payment method for Medicaid prescription drugs that is transparent and reliable, reflects current, real-time prices that pharmacies pay for prescription medications, and will be fair to pharmacy and Medicaid. This new model will meet or exceed the Administration's cost-cutting goal by encouraging dispensing of lower-cost generic drugs.

Brand Name Drugs: Unlike ASP or AMP, wholesale acquisition cost, known as WAC, is a published, transparent, real-time price that reflects the prices at which wholesalers buy from manufacturers the brand name drugs that they sell to independent and chain operated pharmacies.

The actual amount paid to pharmacies by Medicaid, however, should be some percentage markup on WAC (i.e., WAC plus a percentage) because WAC represents the wholesaler's costs to buy the drugs. Retail pharmacies have additional costs of acquiring drugs from wholesalers or manufacturers, such as overhead in maintaining a costly pharmaceutical inventory, delivering the drugs to their stores or warehouses, and complying with state and Federal regulations, such as board of pharmacy and DEA requirements. We believe that "WAC plus a percentage" would be an appropriate substitute for AWP, ASP, or AMP in determining reimbursement for brand name drugs.

Generic Drugs: The CMS Federal Upper Limit (FUL) list has been an effective tool in saving Medicaid money on generic drugs. Several hundred generic products currently have a FUL. States can vary these FUL rates consistent with local market conditions, but Medicaid will pay states no more than the FUL amounts for this market basket of generic drugs with FULs. NACDS has worked closely with CMS over the past several years to make the FUL list more effective in terms of assuring that Medicaid pays a fair price for generics, but also that the generic reimbursements simultaneously encourage pharmacies to dispense generic drugs.

In lieu of WAC, ASP or AMP for multiple source generics, we believe that policymakers should retain the use of this type of list for generic drug reimbursement under Medicaid. However, we encourage that certain changes be made to the way that the list is developed. By using a FUL list or a minimum "federal generic reimbursement level" (FGRL) for all versions of a particular generic, Medicaid assures that pharmacies have an incentive to buy the lowest cost generic available.

This FGRL would be set at a percentage of the median or other market prices for the generic sufficient to encourage generic dispensing. This approach would allow pharmacies to retain some of the difference between the cost of that generic and the FGRL. This creates incentives for pharmacies to dispense generics.

Payment of Adequate Dispensing Fees: NACDS believes that any Medicaid payment reform system that seeks to pay pharmacies closer to their acquisition costs for prescription drugs should pay a higher dispensing fee than currently paid by states. In our view, payment for the drug product plus the dispensing fee must be considered in tandem in order to determine whether reimbursement is adequate. Moreover, we strongly urge that a minimum state Medicaid pharmacy dispensing fee be determined at the Federal level, with provisions made for annual updates. We also urge that states be allowed to increase the fee to account for local concerns, such as assuring adequate access to pharmacy services in rural areas.

The Center for Pharmacoeconomic Studies at the University of Texas at Austin recently conducted a survey of national and regional chain pharmacies to estimate the current costs related to dispensing a medication within those stores. Confidential operational and financial data from the most recent corporate fiscal year was provided to the Center by 40 separate pharmacies representing five geographically-diverse chain pharmacy companies.

The data were collected using a modified survey instrument based upon a financial reporting format that has been used within community pharmacy for well over 20 years. The particular sample used for the analysis was comprised of both high and low-volume Medicaid dispensing pharmacies across the country, representing 13 different states. This sampling method begins to provide us with a description of the broad range of the costs involved in dispensing prescriptions within a chain pharmacy.

Overall, the statistical range of costs of dispensing fell between $8.50 and $10.41 per prescription, with the average within this particular sample being $9.45 per prescription. Given that current payments for dispensing fees fall well below this estimate, the results from this preliminary analysis confirm that more widespread studies are needed to estimate the actual costs of dispensing medications to patients. However, policymakers should consider these findings as any payment system reform proceeds forward, as well as provide for annual updates to the dispensing fees to keep pace with increasing costs to operate a pharmacy, especially pharmacy labor costs.

IV. Conclusion

Mr. Chairman, we look forward to working with you and the Members of the Subcommittee to make sure that the Medicaid prescription drug payment system is reliable, transparent, and reflects the current market prices that retail pharmacies pay for prescription drugs. We want to assure that the system encourages generic dispensing, as well as continues to make pharmacy services available to Medicaid recipients in their communities. This is especially important in urban and rural areas where many Medicaid recipients live.

We also want to work with you to make the Medicaid program in general, and the drug program in particular, financially sustainable in the long run. Over 50 million Americans rely on Medicaid for health care services. Drug coverage is an important part of these needed health care services. Pharmacists can be partners with the Federal Medicaid program and the states in trying to deliver the most cost-effective drug benefit possible. We appreciate your considering these views as you move forward with these efforts.